

STRATEGIES TO IMPROVE COLORECTAL CANCER SCREENING RATES IN BLACK, INDIGENOUS, AND PEOPLE OF COLOR (BIPOC)

Prepared by Catalyst for Payment Reform December 2025



TABLE OF CONTENTS

INTRODUCTION AND ACKNOWLEDGEMENTS.....	3
EXECUTIVE SUMMARY	4
WHAT DOES THE RESEARCH SHOW?	5
SCREENING GUIDELINES	5
INCIDENCE RATES AND TESTING OPTIONS	5
WHAT ARE THE CHALLENGES TO GETTING SCREENED?	6
CULTURAL STIGMAS '.....	7
MEDICAL MISTRUST '.....	9
WHAT CAN YOU DO? STRATEGIES TO ADDRESS CRC SCREENING DISPARITIES.....	10
STAKEHOLDERS	10
STRATEGIES.....	10
WHAT CAN PATIENTS DO?	15
POLICY LANDSCAPE.....	18
LOOKING AHEAD	19
APPENDIX	20

Introduction and Acknowledgements

About Catalyst for Payment Reform

Catalyst for Payment Reform (CPR) is an independent, nonprofit corporation with the mission to catalyze employers, public purchasers, policy makers, and others to implement strategies that produce affordable, high-quality health care and improve the functioning of the health care marketplace.

CPR has hosted various purchaser and multi-stakeholder collaboratives over the past seven years on a variety of topics, including [benefits design](#), [mental health](#), and [accountable care](#). Through these collaboratives, in partnership with subject matter experts, CPR provided participants with hands-on, custom support and published How-to-Guides, toolkits and hosted virtual events to disseminate the collaboratives' learnings to a broader audience.

About the Project

CPR partnered with a large health plan to conduct a systematic review of patient journeys in two clinical areas, identifying opportunities to increase access through benefits design, with the goal of reducing disparities across the populations of focus. The two clinical areas reviewed were:

- a. Pregnancy through delivery for women – examining the disparities in the rate of Cesarean sections between Black and White women.
- b. Colorectal cancer screening – examining the disparities in the rate of colorectal cancer screenings in marginalized Black, Indigenous, and People of Color (BIPOC) communities.

Over a 12-month period, CPR hosted collaborative meetings, convening a diverse group of subject matter experts ranging from employer-purchasers, benefits consultants, and policy experts. CPR also conducted individual interviews with consumer representatives for their insights and perspectives.

Most participants in the collaborative were based in California, which limited the perspective to a single state.

Acknowledgements

CPR appreciates the generous support and partnership of the California Health Care Foundation (CHCF).

CPR thanks Shannon Cosgrove, Eva Durazo, Val Jacobo, and Lisa Young and the participants of the collaborative for their time, effort, and commitment to this project.

CPR also thanks Ryan Olmstead and Kevin Han for their leadership of the collaborative project and CPR staff for their contributions to this report.

Executive Summary

The focus of this report is to share our findings on best practices to reduce disparities in colorectal cancer (CRC) screening rates in patients that identify as Black, Indigenous, and/or People of Color (BIPOC). To use [person-first language](#), the acronym BIPOC will be used throughout this report instead of terms like “marginalized” and “minority.”¹ We will also aim to be specific whenever possible, as we recognize BIPOC is not a monolith.

Disparities exist in CRC screening rates in BIPOC due to multiple factors, including but not limited to access, socioeconomic factors, transportation, and cultural stigmas. To address these disparities, stakeholders need to take focused approaches that consider the entire patient journey, starting from pre-screening to follow-up care.

This report elucidates key research findings resulting from our collaborative discussions, stakeholder interviews, and a literature review, and explores the challenges affecting CRC screening rates among BIPOC populations. We illustrate these challenges by sharing three different healthcare “personas” created using information gathered through research and consumer interviews. We share strategies stakeholders can incorporate in benefits design, policy recommendations, and/or community-based outreach. Stakeholders – including employer-purchasers, health plans, providers, policy advocates, and community-based organizations – have unique roles to play in reducing disparities. Additionally, this report provides patient-friendly resources like template questions that a patient can use when meeting with health plan customer service representatives and/or providers. The report concludes by looking ahead to what’s next in terms of CRC screening options.



What Does the Research Show?

Screening Guidelines

In the United States, CRC is the third most diagnosed cancer and one of the leading causes of cancer death in both men and women. According to the American Cancer Society (ACS), there will be 154,000 new cases of CRC diagnosed in 2025 alone.ⁱⁱ CRC rates are rising in younger people as well. Due to the increasing rate of CRC occurring in younger people, the U.S. Preventive Services Task Force (USPSTF) updated its guidelines and lowered the initial screening age to 45 (it was previously age 50). The USPSTF recommends that adults aged 45 to 75 be screened for colorectal cancer, and the decision to screen people between the ages 76 and 85 should be made on an individual basis.ⁱⁱⁱ

Family history is also a factor to consider for CRC screenings. Enhanced screening guidelines when there is a family history are below (American Society of Colon & Rectal Surgeons):

- Age 40 or 10 years younger than the earliest diagnosis in family when first-degree relative is diagnosed with CRC or adenomatous polyps under the age of 60.
- Age 40 when first-degree relative is diagnosed with CRC or adenomatous polyps at 60 or over.

Incidence Rates and Testing Options

Data shows there is a higher incidence rate for CRC among BIPOC. Surveillance, Epidemiology, and End Results (SEER) Program data from 2000-2017 found that non-Hispanic White individuals are the most up to date with CRC screening participation (60%), followed by non-Hispanic Black (59%), American Indian/Alaska Native (52%), Hispanic (51%), and Asian (48%) individuals.^{iv}

Black Americans have the highest CRC incidence rate (41.9 per 100,000), followed by American Indian (39.3), White (37), Hispanic (33.5), and Asian/Pacific Islander (31.7). Data for CRC mortality follows the pattern of the incidence rates.^v

Survival rates can depend on the stage the CRC is detected.^{vi} SEER data indicate that the five-year survival rate for localized CRC is >90%, while the survival rate for distant CRC is <20%.^{vii}

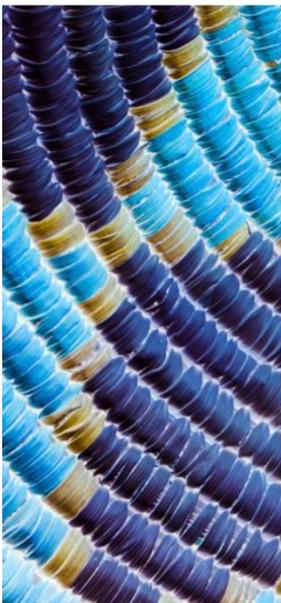
There are several testing options for CRC, including fecal immunochemical test (FIT), blood test, computed tomography (CT) scan, and colonoscopy. In both Randomized Controlled Trials (RCTs) and observational studies, evidence-based interventions including mailed FIT outreach and patient navigation have been shown to improve CRC screening rates while decreasing disparities in CRC screening and mortality affecting BIPOC populations. A 2024 study published in the journal [Techniques and Innovations in Gastrointestinal Endoscopy](#) (TIGE) shows that offering multiple testing options is also an evidence-based strategy for optimizing screening.^{viii}

What are the Challenges to Getting Screened?

The health system is filled with barriers that make it harder for BIPOC individuals to get screened for CRC and to receive necessary follow-up care. Socioeconomic factors can impact someone's access to screening, and cultural stigmas of CRC screening exist in subpopulations.

As mentioned above, we have developed three patient personas we hope will paint a clear picture of the challenges BIPOC face in accessing CRC screening. Each persona is paired with a barrier that was identified in the research and collaborative meetings. Patient personas are grounded in research but developed with hypothetical elements to offer detailed insights that can help stakeholders meet patients' needs.

Note: These are example personas and are meant to be illustrative and not representative of entire communities/populations. The information included in each description is based on peer-reviewed research and/or interviews with community members. The images were generated with AI.



Cultural Stigmas ^{ix,x}

Stigmas can look different in different cultures, yet some can be pervasive across all cultures. According to a study in Men's Health Network, men described colonoscopies as an invasive procedure. They felt it would undermine their masculinity and that others in their community would feel it did, too.

Meet Samuel, a Latino male of Mexican descent in his early 40s. Samuel grew up in a “machismo”¹ culture, which can be described as a socially constructed, contextually dependent masculine identity that is associated with positive work ethic, loyalty to family and culture, as well as displays of physical aggression and dominance. Despite a family history of CRC, Samuel was hesitant to get screened. He recalled family conversations where folks would joke that after a colonoscopy, men seemed to “walk differently” implying that the procedure could awaken latent homosexuality. While talking with his cousin, Samuel expressed these fears and that other people in the community would find out, especially because he couldn't drive himself home after the procedure. His cousin, who is ten years older than Samuel, advised him to get the colonoscopy and talk to his doctor about his concerns. He told Samuel, “I wish I had done it at your age, now I'm afraid that if I do it now, I will find out that I have cancer because I am older.”

Samuel's experience aligns with what we heard from our interviewees and in peer-reviewed literature, which is that cultural stigmas, whether it is religious or socially constructed, can discourage people from getting screened for CRC.



¹CPR recognizes that the term *machismo* is complex and has been used in academic literature in ways that can pathologize or stigmatize Hispanic and other men. While we considered alternative terminology, we ultimately chose to retain *machismo* to reflect the language used by study participants themselves, in the literature referenced, when discussing their reluctance to pursue colorectal cancer screenings.

Access ^{xi, xii, xiii, xiv}

Socioeconomic factors play a role in access to CRC screening. This can take shape in many ways, whether it is differences in education, income, or health insurance.

Diana is an Asian American female of Vietnamese descent in her mid-50s. She has been a homemaker and caregiver to her sick mother and relies financially on her husband's hourly pay and money from their daughter; her family is unable to absorb extra medical expenses or surprise medical bills. In the past, Diana had preventive annual health screenings, which she expected to be covered completely with no cost-sharing. However, a past medical visit was coded as diagnostic, leaving Diana with surprise bills. Diana is concerned about additional surprise bills and is hesitant to schedule a follow up screening even though she has been experiencing changes in bowel habits and some abdominal pain. Her doctor is recommending CRC screening; however, English is not her first language, and Diana is struggling to get clarity on how the procedure will be coded and billed. She would feel more confident speaking with a customer service representative in her native language but has been unable to do so and therefore continues to delay testing due to the concern of unexpected medical bills. Adding to her stress is the concern that delaying the screening increases the likelihood of a positive diagnosis.



Medical Mistrust ^{xv, xvi, xvii, xviii, xix}

Trust between the provider and the patient is imperative in a patient's care journey, yet many BIPOC patients have personal and historical racially-based medical trauma which informs a mistrust of doctors, hospitals, and insurers. These psychosocial influences remain a primary barrier for reduced uptake of cancer screenings, including CRC.

Gabrielle, a Black woman in her mid-40s, recently had a family member diagnosed with CRC. Out of precaution, Gabrielle considers talking to her doctor about obtaining a Fecal Occult Blood Test (FOBT) or colonoscopy, but she is hesitant. She has experienced racially-based medical trauma, including being denied the standard dose of pain medication during an emergency department visit and the loss of her brother due to a preventable medical error. These experiences have left deep scars and a lasting mistrust in the health care system. As a public health researcher, she is aware that Black people are more likely to receive a CRC diagnosis at a younger age, have a higher mortality rate from CRC, and are 8% less likely to have screening colonoscopies than other groups, leading to a greater likelihood of late-stage detection. When she talked with her sister about it, her sister shared that she had been tested but wasn't sure she trusted the results. She reached out to her doctor for input but never heard back, which reinforced the medical mistrust Gabrielle and her sister shared. Gabrielle ultimately decided to talk to her doctor about receiving the test, but he was hesitant to order it saying she is just under the recommended age and did not think it was necessary; however, Gabrielle insisted.



What Can You Do? Strategies to Address CRC Screening Disparities

As the three personas illustrate, BIPOC patients face unique challenges accessing CRC screenings. There is no one-size-fits-all solution, but there are ways that different stakeholders in the healthcare system can address these screening disparities. Together, stakeholders can alleviate the burden through benefits design, policy, and community-based work.

Stakeholders

Employer-purchasers - Many people get their health coverage from their employer – in 2023, [178 million people](#), or 68% of working-age adults, have employer-sponsored insurance. Employers and other healthcare purchasers can utilize benefits design, data, and advocacy to address disparities in CRC screenings.

Health Plans - Whether covered by an employer or through private individual insurance, people depend on their health plans for access to benefits.

Providers - Health care providers offer one-on-one, human interaction with patients. By building trust and recognizing the barriers that BIPOC patients face, providers can help address CRC screening disparities.

Community-based Organizations (CBOs) - CBOs play an essential role in the respective communities they serve through direct services, community education and outreach, and policy advocacy.

Strategies

Expand Coverage Through Benefits Design

This strategy is targeted toward employer-purchasers and health plans.

Stakeholders can expand the coverage of CRC screening options through benefits design.

Benefits design determines how much the health plan and the patient will pay for covered health services, from which providers the patient can seek care, and under what circumstances or medical necessity requirements are the services covered. Benefits design can close care gaps through the following mechanisms:

- Reducing or eliminating financial barriers to health services.
- Providing coverage for additional services.
- Signaling to patients which services are of high-value and important to foster good outcomes.

Health plans can evaluate covering non-invasive screening options based on accuracy, accessibility, and cost (e.g., blood, CT). When designing benefits, health plans should consider the full patient care journey, which can range from bowel preparation for a colonoscopy to any follow-up diagnostic procedures. Health plans should also review coverage for bowel preparation medication and revise as necessary to include 100% coverage for low-volume

bowel preparation.² An out-of-pocket copay may limit patients to high-volume bowel preparation, and as a result, patients may refuse and forego screening.

Health plans can expand preventive coverage to cover asymptomatic colonoscopies where a polyp is discovered; polyp removal should not increase patient costs. Following the implementation of the Affordable Care Act (ACA), certain preventive colonoscopies were billed as “diagnostic” if a polyp was removed during the procedure. However, federal guidance now clarifies that polyp removal is an integral part of a screening colonoscopy. Therefore, patients with private insurance should not incur out-of-pocket costs, though individuals on Medicare may have to pay 15% of the Medicare-approved amount.^{xx}

Health plans can reduce or eliminate cost-sharing for colorectal cancer screenings for high-risk patients who are under the age of 45, and for diagnostic procedures and follow up colonoscopies. This is crucial as these individuals are more susceptible to colon cancer and by minimizing barriers to early detection, the number of colon cancer-related deaths can significantly decrease.

“Patients want to see their doctor, not a health system.”

-Provider with experience in CRC screening

Health plans can also relax or remove prior authorization requirements for colonoscopies. [Recently](#), several insurers agreed to make fewer procedures subject to prior authorization. Providers CPR talked to recommended that

health plans support local physician-owned practices through higher reimbursement. This will allow such practices to move into and care for local communities better than large health systems and private equity-backed practices that “seem to be taking over medicine.” Health plans can update provider directories regularly so that patients can identify high-value, in-network outpatient facilities and providers.

Non-emergency medical transportation (NEMT) is another potential benefit, and stakeholders can find vendors that offer post-colonoscopy transport options. For example, Lyft Healthcare [provides access](#) to Medicaid NEMT services in 21 states, covering more than 62% of Medicaid beneficiaries. CPR member TennCare piloted [Medicaid NEMT](#) and permanently authorized its use in January 2023. In the appendix section, please see a sample benefit guide section template that an employer may be able to incorporate into their benefits guide. While NEMT is a promising solution to increase colonoscopy screening, there may be regulatory requirements (or restrictions) that prevent health plans from adding NEMT for specific procedures, and coverage may vary by type of plan (e.g., Medicaid vs. commercial coverage).

Employer-purchasers are exploring the FIT as a simpler alternative to traditional methods like a colonoscopy. FITs require no preparation and are easier for patients to complete in the comfort of their own home. Employers can incentivize FIT through wellness programs. This can potentially increase screening rates, particularly among those hesitant to undergo traditional screenings. Additionally, at-home FITs address patient barriers of limited paid time off and transportation options.

Utilize Data

This strategy is targeted toward employer-purchasers and health plans.

² Low-volume kits typically involve drinking a smaller amount of solution, often in split doses. This may be easier than high-volume preparation.

Employer-purchasers can promote data-driven accountability and hold plans accountable for achieving CRC screening metrics by requiring health plans to report CRC screening data stratified by race and ethnicity. Employer-purchasers should connect the collection and reporting of stratified data to plan performance by making CRC screening a priority measure in their contractual agreements with health plans/Third-Party Administrators (TPAs).³ Through the contracting process, purchasers can enforce race/ethnicity stratification in quality reporting with their TPA. Additionally, health plans can use value-based payment or pay-for-performance incentives with their network of providers to collect race and ethnicity data to reduce health disparities. Employer-purchasers can also ask their health plan to report their colorectal cancer screening rates using a denominator of the total number of plan members who are eligible for screening.^{xxi} Collaborative participants recommended analyzing data elements like race/ethnicity stratification, FIT testing data, and benefit utilization. While the data may be imperfect, it can be a tool to address coverage issues.

Covered California (Covered CA), the state-based marketplace that connects nearly 2 million Californians to high-quality, affordable health insurance, implemented a program called the Quality Transformation Initiative (QTI). This initiative ties financial accountability to performance above the national 66th percentile performance threshold for a core set of quality measures. One of the four QTI measures is a colorectal cancer screening measure. Covered CA shared with the collaborative members that QTI led to contracted plans improving their performance on the colorectal cancer screening measure, along with other QTI measures. From Measurement Year 2022 to 2023, the number of plans performing at or above the 66th national percentile increased from one (1) plan to four (4) plans.

Covered CA collects its data based on the Quality Rating System (QRS) colorectal cancer screening measure, which is a publicly reported, standardized measure. Covered CA also uses national benchmarks based on health plans' submissions for their colorectal cancer screening



rates among their eligible populations.⁴ Starting in 2026, Covered CA will hold contracted plans

³ In the health care industry, a third-party administrator (TPA) is an administrative services provider that delivers support for self-insured health plans.

⁴ <https://hbex.coveredca.com/data-research/plan-performance-reports/>

accountable for racial-ethnic subpopulation performance. Covered CA uses funds from QTI to invest in population health initiatives. The model will be monitored to ensure gaps between populations are closing—moving closer to improved access.

The table below shows plan performance on CMS' QRS colorectal cancer screening measure from MY 2019 to MY 2023. The number of plans that performed above the 66th percentile increased from 1 in MY2022 to 4 in MY2023. The “percent of enrollees” refers to the portion of all enrollees enrolled in plans that achieved that performance level.

Colorectal Cancer Screening	MY 2019	MY 2020	MY 2021	MY 2022	MY 2023			
	US Benchmark	Percent of Enrollees	Number of Enrollees	Number of Plans				
Plans at 90th Percentile and Above	69 +	68 +	68 +	72 +	68 +	35%	584,910	1
Plans at 66th to 90th Percentile	61 to <69	61 to <68	61 to <68	63 to <72	61 to <68	11%	189,350	3
Plans at 50th to 66th Percentile	55 to <61	57 to <61	57 to <61	58 to <63	57 to <61	26%	439,350	3
Plans at 25th to 50th Percentile	47 to <55	50 to <57	50 to <57	49 to <58	47 to <57	20%	336,570	4
Plans Below 25th Percentile	Below 47	Below 50	Below 50	Below 49	Below 47	7%	112,910	3
Covered California Plan-Specific Performance	MY 2019	MY 2020	MY 2021	MY 2022	MY 2023*			
Anthem HMO			60	56	50	8%	127,360	
Anthem EPO	45	48	51	53	50	5%	79,630	
Blue Shield HMO	59	49	60	60	61	9%	148,550	
Blue Shield PPO	51	49	53	58	58	21%	342,590	
CCHP HMO	60	49	60	53	55	<1%	2,900	
Health Net HMO	62	54	56	57	60	4%	67,880	
Health Net PPO	40	34	32	44	45	2%	41,140	
Kaiser Permanente HMO	76	69	74	73	70	35%	584,910	
LA Care HMO	54	46	46	43	48	8%	126,680	
Molina Healthcare HMO	31	33	37	38	34	3%	51,970	
Oscar Health Plan EPO	36	29	35	50	61	2%	30,790	
Sharp Health Plan HMO	66	71	67	58	60	2%	28,880	
Valley Health Plan HMO	54	44	49	46	39	1%	19,800	
Western Health Advantage HMO	52	52	56	56	62	<1%	10,010	

Source: [Covered California publicly available plan performance report](#)

Invest in Education

This strategy is targeted toward employer-purchasers, health plans, providers, and CBOs.

Employers can share informational resources with employees regarding CRC screening options, screening guidelines based on age and risk factors, and contact information for assistance. Such materials can be produced internally or externally.

Employer-purchasers who offer a preferred provider product (PPO) can take steps to ensure employees are informed of their in-network options. They should work with their TPA or health plan to identify high-value, in-network outpatient facilities and providers and have these providers clearly identified in the health plan network directory.^{xxii}

Health plans can remind plan members when it is time for a CRC test and send them a [FIT kit for at-home testing](#). [Kaiser Permanente Northern California \(KPNC\) implemented its integrated colorectal cancer screening program](#) starting in 2006, which sends people reminders that it is time for their CRC test and sends them a FIT kit for at-home testing. Kaiser Permanente found

that in the 13 years since its launch, the program helped reduce cancer incidence by a third, halved the number of deaths, and eliminated racial differences in outcomes. A study conducted by Kaiser Permanente found that since the initiative's launch, CRC screening rates — with options like colonoscopy, sigmoidoscopy, or FIT testing — more than doubled across all racial and ethnic groups, increasing from 37.4% in 2000 to 79.8% in 2019.^{xxiii, xxiv}

The difference between preventive and diagnostic care is not always clear to patients. Providers should equip patients with clear and thorough information on what is covered in a preventive vs. diagnostic colonoscopy and explain what scenarios could potentially change the claim from preventative to diagnostic. Being proactive and transparent will help the patient make an informed decision and build trust.

Stakeholders can partner with organizations like [Zócalo Health](#), a primary care group providing social and clinical care to Latino communities and purchasers, to educate and reduce stigmas around CRC screening. Zócalo Health supports patients on a broad range of clinical issues and educating on CRC screening is a focus area. Staff target at-risk community members in the recommended testing age range and provide FIT kits for them to take home if they are uncomfortable seeking services at the doctor's office.

CBOs can help consumers navigate the local healthcare system, whether they want to understand their covered benefits or they are looking outside of their in-network benefits. CBOs can provide essential information in different languages and alternative formats, bring awareness to post-colonoscopy transportation programs and partner with clinics that offer such programs. By creating a safe space for dialogue and overcoming language barriers, CBOs can help build trust with community members.

Encouraging the use of electronic communication technology may contribute to improved health information literacy and reduced disparities. Online communication can empower patients with linguistic and culturally diverse backgrounds to interact more confidently with health care providers.^{xxv}

More individuals have access to free CRC screenings thanks to new policies that eliminate surprise bills and designate CRC screenings as preventive care. However, **doctors and facilities play an important role in submitting the correct procedure and diagnosis codes so patients do not face surprise bills.** Providers should use coding guides like [this one](#) from the American Gastroenterological Association. For example, one must add modifier 33 (preventative services) to CPT code 45378 for patients with commercial insurance to prevent them from being inappropriately billed.

Health plans and providers can work together and educate each other to ensure proper billing for eligible CRC screening procedures. Health plans can update claims processing systems to allow any preventive claims that are billed as diagnostic to be fully covered.

Improve Access to Testing

This strategy is targeted toward employer-purchasers, health plans, providers, and CBOs.

Expanding benefits is only part of the puzzle; patients need easier access to CRC testing options.

As part of an annual preventive care visit, covered benefits should include onsite FIT, or at-

home stool tests such as FIT or multi-target DNA tests. Prior to patient appointments, providers and provider offices can explain the test and how it is performed, as well as the need for a follow-up colonoscopy for all positive stool tests. Stakeholders like providers can utilize a registry to track patients with positive stool tests to ensure follow-up colonoscopies and conduct treatment referrals for those with cancer detected during a colonoscopy. Prompt follow-up will also reduce health disparities in BIPOC populations.

Due to sedation during a colonoscopy, patients are not fit to operate a vehicle for a few hours after the procedure and providers will not typically perform a colonoscopy if the patient has not arranged for post-procedure transportation.^{xxvi} Due to safety concerns, [guidance varies](#) regarding whether [rideshare is an option](#) when a family member is not available to pick up the patient.

A first-of-its kind rideshare study published in 2023 showed that, if given a way to get home from a colonoscopy after sedation, many patients will seek out a procedure they would otherwise avoid. Over 95% of patients reported the rideshare NEMT was a very positive experience (only 1 patient did not report the experience as positive; however, they still stated they would use it again and recommend it to others).^{xxvii}

CBOs can apply for funding to run FIT kit campaigns in vulnerable communities. In California for example, [C4 \(California Colorectal Cancer Coalition\)](#) funded multiple community health centers to improve access to CRC screening.

Strategic partnerships can help incentivize screenings. The [American Cancer Society and Color Health](#) have partnered with Federally Qualified Health Centers (FQHCs) and community health clinics to make at-home CRC screening freely available, as well as making diagnostic follow-up support available, with results to be shared in early 2025. Promise Community Health Center offered [\\$30 gift cards](#) as an incentive for completing and mailing back a FIT.

Stakeholders can become policy advocates and/or identify partners that advocate for policies that are related to CRC screening. Stakeholders are encouraged to tap into community members who can share public testimonials and think creatively. For example, advocates can utilize social/digital media to generate attention to an issue.

What Can Patients Do?

The stakeholders listed previously can do their part to improve the patient journey, and with the proper tools and information, the patient can serve as their own best advocate. Many entities, including health plans, facilities, and states, have a [Patient Bill of Rights](#) that outlines what patients can expect when getting care and help them make informed decisions. Below is a checklist of questions that a patient or consumer can ask their employer, health plan, or provider when determining their need for CRC screening.

Patient Question Checklist

Questions to ask your employer:

- What is the paid time off policy for the full colonoscopy procedure – pre-procedure bowel preparation, the colonoscopy, and post-procedure recovery?
- Do I have access to virtual care, or a patient navigation service?

Questions to ask your health plan:

- Do I have a Patient Bill of Rights or list of rights and responsibilities? If yes, where/how can I access it?
- How can I get a FIT test? What's the lowest out-of-pocket cost option for a FIT kit? Is it possible for the test to be fully covered by insurance?
- If a FIT isn't available or not the chosen method:
 - Which bowel preparation medications are covered by the plan? Are any of these low-volume medications?
 - How does my plan cover a colonoscopy if I'm under 45 years old? What if I am high-risk due to family history?
 - If I have a preventive/screening colonoscopy and the provider removes a polyp, how is everything covered (the bowel preparation medication, the colonoscopy and anesthesia, the biopsy/lab testing, and any potential facility fees)?
 - In the event there are post-colonoscopy complications, how are those services covered under my plan?

Question to ask your provider:

- Do I have a Patient Bill of Rights or list of rights and responsibilities? If yes, where can I access it?
- Can I complete a FIT kit today? If not, can you refer me to an in-network lab for the service?
- What is the cost and coverage estimate for the colonoscopy, including any facility fee, anesthesia, the procedure, and any additional services?
- Which bowel preparation medication should I get for the colonoscopy? Can I receive a prescription for a low-volume option?
- Is the claim submitted as preventive or diagnostic if the provider finds and removes a polyp for testing?
- What transportation options are available? Does the facility have any arrangements with transportation companies? If no family member or friend is available, am I able to arrange my own transportation?

Policy Landscape

Policy can have a positive impact on addressing disparities in CRC screening. There has been legislation in various states regarding facility fees and subsequent surprise billing, which can help patients avoid unnecessary fees. However, there have been legal challenges which can impact access to CRC screenings.

Kennedy v. Braidwood (which was formerly named Braidwood v. Becerra) was a challenge to the ACA's coverage mandate of preventive services.^{xxviii} On January 10, 2025, the Supreme Court agreed to hear an appeal in this case. On February 18, 2025, the Trump Administration agreed to take over the case, arguing that the HHS Secretary has ultimate oversight of the USPSTF members and its recommendations.^{xxix} [On June 27, 2025](#), the Supreme Court preserved coverage of preventive health care, like colonoscopies. While coverage remains intact, the court decision also raises questions of whether [Secretary of Health and Human Services Robert F. Kennedy Jr. plans to alter the USPSTF membership](#).

U.S. hospitals charge [facility fees](#)⁵ for colonoscopy procedures covered by private health insurance that are on average approximately 55 percent higher than facility fees billed by ambulatory surgical centers, according to a [study led by researchers at the Johns Hopkins Bloomberg School of Public Health](#).

States like New York have passed [legislation](#) related to the regulation of the billing of facility fees and requires notice prior to billing facility fees not covered by a patient's insurance.

There is significant [activity](#) among states as it relates to facility fees.

- CO, CT, MD, and NY: Require notification before services are provided.
- FL: Freestanding ER departments must disclose average facility fees on a posted sign.
- IN: Annual state filings to report revenue.
- CT: Lists certain outpatient services for which providers can't charge facility fees.
- CO and NY: Prohibit facility fees for preventive services.

Stakeholders, particularly patient advocates and employer groups should work to introduce and advance legislation that eliminates or limits facility fees for services performed outside a facility, including preventive services.

⁵ A "facility fee" is an example of an overhead cost that supports the emergency room and other services the hospital must provide but are not directly related to the care the patient received. Hospitals are imposing facility fees for services that are not performed in a facility. This can result in the same service costing different amounts depending on whether you get it in an independent physician's office or one that is owned by a hospital, driving up costs for patients and the health system more generally.

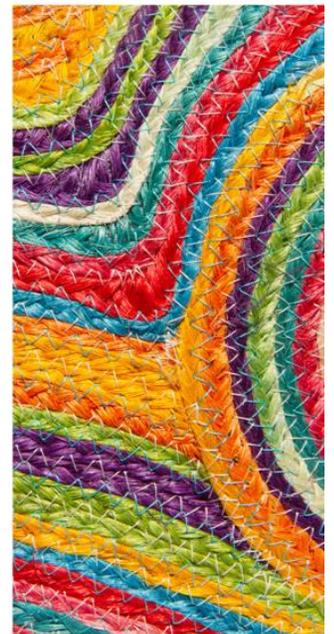
Looking Ahead

There is no one-size-fits-all solution to reducing the disparities in CRC screening rates among the BIPOC community. As we've shared here, there are various factors and considerations, and each subgroup within the BIPOC community has its own unique challenges to screening.

Stakeholders can act now to address these disparities in CRC screening, and thus reduce CRC mortality rates for BIPOC. Across the stakeholder groups, some key strategies overlap: 1) tracking and utilizing data to promote accountability; 2) providing people with information and access to testing services through culturally appropriate outreach; and 3) lowering and limiting health care costs by eliminating potential surprise billing/facility fees through purchaser strategy and policy. Patients can be their own best advocate and be proactive in their health care by utilizing the template questions provided in this report.

Other alternative testing options are on the horizon. Blood tests, like Shield, have recently been approved by the FDA and serve as a potential alternative to FIT or colonoscopies, since Shield could be ordered as part of a standard blood draw. However, it may be too soon to tell whether it is more cost-effective.^{xxx} On the data front, NCQA is working with the Council of Medical Specialty Societies and the American Gastroenterological Association to develop a new HEDIS[®] measure to improve follow-up care for patients with abnormal colorectal cancer screening results.^{xxxi}

It is essential that people have access to free testing, whether using an at-home FIT or a preventive colonoscopy. Information is powerful, and providing patients with critical information on their options and working proactively to avoid surprise costs will help restore patient trust in the healthcare system that has been lost. CPR hopes to continue to collaborate with interested parties to examine other disparities that specific communities face in the health care system, and highlight actionable strategies stakeholders can use to address the inequities in a patient's care journey from start to finish.



Appendix

Disclaimer: Please note that the information provided here by CPR is for informational purposes only and is provided as guidance for consideration. It is always recommended to consult with a qualified benefits consultant tailored to your situation. Any of these provisions can be modified to fit your benefit design needs.

Sample Employer Benefit Guide - Preventive Care Transportation Benefit: Colorectal Cancer Screening Support

Purpose

To ensure equitable access to preventive colorectal cancer (CRC) screening, this benefit provides non-emergency medical transportation (NEMT) for members traveling to and from a colonoscopy appointment or related consultation.

Covered Services

Transportation is available for the following:

- Preventive colonoscopy for average-risk members (ages 45–75)
- Colonoscopy following a positive FIT or stool-based test
- Pre-procedure appointments directly related to CRC screening

Eligibility

Transportation support is available for:

- Members with no reliable access to personal or public transportation
- Members who live more than 15 miles from the provider location
- Members who require an escort due to sedation requirements

Eligible participants include⁶:

- Employees
- Spouses or domestic partners
- Dependents (age 18+)
- Retirees and COBRA participants (depending on employer policy)

Transportation Options

- Rideshare services (e.g., Uber Health, Lyft Healthcare)
- Private shuttle or car service

⁶ Plan sponsors can modify this list to accommodate their individual needs.

- Wheelchair-accessible vehicles, as needed
- Coverage for escort or caregiver, if medically required

Cost to Member

Transportation is provided at **no out-of-pocket cost** when scheduled through the approved vendor or health plan representative. Prior authorization may be required.

How to Schedule a Ride

1. Call the transportation vendor or plan hotline at least 48 hours before your appointment
2. Provide your appointment details and any special accommodations needed
3. Confirm pick-up time and location

Contact: [Insert TPA/Plan Phone Number or Portal URL]

Language and Accessibility

- Support is available in multiple languages [list available languages here]
- Interpretation services may be requested when scheduling

Equal Access Commitment

This benefit aims to close gaps in CRC screening access across race, ethnicity, income, and geography. Employer-purchasers and plans will:

- Monitor usage data by ZIP code and demographics
- Incorporate transportation utilization into performance reviews
- Ensure outreach is inclusive and culturally appropriate

Additional Support

If you need help coordinating your screening, contact our wellness or care navigation team. Assistance with scheduling, transportation, and follow-up is available.

Wellness Program Tie-In (Optional)

Employees who complete a colonoscopy or annual FIT may also be eligible for a wellness incentive. See page [X] for more information on screening rewards.

ⁱ Raypole, C. (2021, November 9). *The difference between “BIPOC” and “POC” matters - here’s why*. Healthline. <https://www.healthline.com/health/bipoc-meaning#meaning>

ⁱⁱ Staff, C. (2025, April 14). *Colorectal cancer rates are skyrocketing in young adults-is your lifestyle putting you at risk?*. Cancer Research Institute. <https://www.cancerresearch.org/blog/march-2025/colorectal-cancer-awareness-month>

ⁱⁱⁱ Centers for Disease Control and Prevention. (n.d.). *Screening for colorectal cancer*. Centers for Disease Control and Prevention. <https://www.cdc.gov/colorectal-cancer/screening/index.html>

^{iv} *Cancer of the colon and rectum - cancer stat facts*. SEER. (n.d.). <https://seer.cancer.gov/statfacts/html/colorect.html>

^v *Cancer of the colon and rectum - cancer stat facts*. SEER. (n.d.). <https://seer.cancer.gov/statfacts/html/colorect.html>

-
- vi *Stages of colorectal cancer*. Canadian Cancer Society. (n.d.). <https://cancer.ca/en/cancer-information/cancer-types/colorectal/staging#:~:text=When%20describing%20the%20stage%2C%20doctors,from%20the%20colon%20or%20rectum> .
- vii *Cancer of the colon and rectum - cancer stat facts*. SEER. (n.d.). <https://seer.cancer.gov/statfacts/html/colorect.html>
- viii Kim, S. H., Prajapati, D. P., & Gupta, S. (2024, March 16). *Extending the reach of colorectal screening to all populations in the United States*. Techniques and Innovations in Gastrointestinal Endoscopy. <https://www.sciencedirect.com/science/article/pii/S2590030724000175>
- ix Mojica CM, Vargas N, Bradley S, Parra-Medina D. Barriers and Facilitators of Colonoscopy Screening Among Latino Men in a Colorectal Cancer Screening Promotion Program. *American Journal of Men's Health*. 2023;17(3). doi:[10.1177/15579883231179325](https://doi.org/10.1177/15579883231179325)
- x Getrich CM, Sussman AL, Helitzer DL, Hoffman RM, Warner TD, Sánchez V, Solares A, Rhyne RL; RIOS Net Clinicians. *Expressions of machismo in colorectal cancer screening among New Mexico Hispanic subpopulations*. *Qual Health Res*. 2012 Apr;22(4):546-59. doi: 10.1177/1049732311424509. Epub 2011 Nov 8. PMID: 22138258; PMCID: PMC3636712.
- xi Warren Andersen S, Blot WJ, Lipworth L, Steinwandel M, Murff HJ, Zheng W. Association of Race and Socioeconomic Status With Colorectal Cancer Screening, Colorectal Cancer Risk, and Mortality in Southern US Adults. *JAMA Netw Open*. 2019;2(12):e1917995. doi:10.1001/jamanetworkopen.2019.17995
- xii Werner, C. (2023, January 12). *Addressing racial disparities in colorectal cancer*. Healthline. <https://www.healthline.com/health/colorectal-cancer/racial-disparities-in-colorectal-cancer>
- xiii Kimura A, Sin MK, Spigner C, Tran A, Tu SP. Barriers and facilitators to colorectal cancer screening in Vietnamese Americans: a qualitative analysis. *J Cancer Educ*. 2014 Dec;29(4):728-34. doi: 10.1007/s13187-014-0646-6. PMID: 24756545; PMCID: PMC4334440.
- xiv Walsh, J.M.E., Kaplan, C.P., Nguyen, B., Gildengorin, G., McPhee, S.J. and Pérez-Stable, E.J. (2004), Barriers to Colorectal Cancer Screening in Latino and Vietnamese Americans. *Journal of General Internal Medicine*, 19: 156-166. <https://doi.org/10.1111/j.1525-1497.2004.30263.x>
- xv Werner, C. (2023, January 12). *Addressing racial disparities in colorectal cancer*. Healthline. <https://www.healthline.com/health/colorectal-cancer/racial-disparities-in-colorectal-cancer>
- xvi Ozawa S, Sripad P. How do you measure trust in the health system? A systematic review of the literature. *Soc Sci Med*. 2013 Aug;91:10-4. doi: 10.1016/j.socscimed.2013.05.005. Epub 2013 May 14. PMID: 23849233.
- xvii Pew Research Center, April 2022, "Black Americans' Views of and Engagement With Science."
- xviii Carethers JM. Racial and ethnic disparities in colorectal cancer incidence and mortality. *Adv Cancer Res*. 2021;151:197-229. doi: 10.1016/bs.acr.2021.02.007. Epub 2021 May 5. PMID: 34148614; PMCID: PMC9069392.
- xix Adams LB, Richmond J, Corbie-Smith G, Powell W. Medical Mistrust and Colorectal Cancer Screening Among African Americans. *J Community Health*. 2017 Oct;42(5):1044-1061. doi: 10.1007/s10900-017-0339-2. PMID: 28439739; PMCID: PMC5654700.
- xx American Cancer Society. (2025, February 27). *Insurance coverage for colorectal cancer screening*. <https://www.cancer.org/cancer/types/colon-rectal-cancer/detection-diagnosis-staging/screening-coverage-laws.html>
- xxi Ibid
- xxii Koh, Y. (2024, January 5). *Third Party administrator: What is a TPA in Health Insurance*. Collective Health. <https://collectivehealth.com/blog/benefits-shop-talk/what-is-tpa-insurance/>
- xxiii Rochman, S. (2025, April 25). *Colorectal cancer screening program doubled screening rates and halved deaths*. Kaiser Permanente Division of Research. <https://divisionofresearch.kaiserpermanente.org/colorectal-cancer-screen-program/>

-
- ^{xxiv} Levin, T. R., Corley, D. A., Jensen, C. D., *et al* (2018). Effects of Organized Colorectal Cancer Screening on Cancer Incidence and Mortality in a Large, Community-based Population. *Gastroenterology*, 155(5), 1383–1391. <https://doi.org/10.1053/j.gastro.2018.07.017>
- ^{xxv} Oh, K.M., An, K., Lee, M. *et al*. Colorectal cancer screening disparities in Asian Americans: the influences of patient-provider communication and social media use. *Cancer Causes Control* 34, 813–827 (2023). <https://doi.org/10.1007/s10552-023-01720-z>
- ^{xxvi} DeMarco, C. (n.d.). *Colonoscopy anesthesia: 7 things to know*. MD Anderson Cancer Center. <https://www.mdanderson.org/cancerwise/colonoscopy-anesthesia--7-things-to-know.h00-159618645.html#:~:text=Can%20patients%20ever%20drive%20themselves,member%20can%20take%20you%20home.>
- ^{xxvii} Bell-Brown, A. (n.d.). *Early results from a pilot rideshare intervention to improve...* . DDW ePoster Library. https://eposters.ddw.org/ddw/2023/ddw-2023/378401/ari.bell-brown.early.results.from.a.pilot.rideshare.intervention.to.improve.html?f=menu%3D16%2Abrowseby%3D8%2Asortby%3D2%2Ace_id%3D2482%2Aot_id%3D27741%2Atrend%3D19514%2Amarker%3D4154
- ^{xxviii} Team, T. A. N. (2025, April 21). *Supreme Court case may impact access to no-cost colorectal cancer screenings*. American College of Gastroenterology. <https://gi.org/2025/04/17/acg-scotus-crc/>
- ^{xxix} Team, T. A. N. (2025, April 21). *Supreme Court case may impact access to no-cost colorectal cancer screenings*. American College of Gastroenterology. <https://gi.org/2025/04/17/acg-scotus-crc/>
- ^{xxx} Voss, A. (n.d.). *Shield blood test approved for colorectal cancer screening*. Shield Blood Test Approved for Colorectal Cancer Screening - NCI. <https://www.cancer.gov/news-events/cancer-currents-blog/2024/shield-blood-test-colorectal-cancer-screening>
- ^{xxxi} Kolinski, B. (2025, March 17). *NCQA is developing a new HEDIS measure for colorectal cancer screening follow-up*. NCQA. <https://www.ncqa.org/blog/ncqa-developing-hedis-measure-for-colorectal-cancer-screening-follow-up/#:~:text=There%20are%20five%20screening%20types,measure%20development%20follows%20this%20process:>